DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **04-04**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **February 2, 2004**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY **2004** **$0.00**
b. FFY **2005** **$0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pre-Print Page 89

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 98-04)

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to designate Frederick P. Cerise, M.D., M.P.H. as the person authorized to sign Form 179 to submit changes to the Medicaid State Plan.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Frederick P. Cerise, M.D., M.P.H.

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 5, 2004

16. RETURN TO:
State of Louisiana
Department of Health and Hospitals
1201 Capitol Access Road
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 18 MARCH 2004

18. DATE APPROVED: 25 MARCH 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
2 FEBRUARY 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
ANDREW A. FREDRICKSON

22. TITLE: ASSOICATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

FORM HCFA-179 (07-92)

Revision: HCFA-PM-97-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: LOUISIANA

Citatation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid agency will provide the opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☒ Not applicable. The Governor- -

☒ Does not wish to review state plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

DEPARTMENT OF HEALTH AND HOSPITALS
(Designated Single State Agency)

Date: 2/2/2004

(Signature)

SECRETARY
(Title)

STATE Louisiana DATE REC'D 18 Mar 2004 DATE APPV'D 25 Mar 2004 DATE EFF 2 Feb 2004 HCFA 179 04-04	A

TN# 04-04 Approval Date 25 Mar 04 Effective Date 2 Feb 04
Supersedes
TN# 98-04

SUPERSEDES TN- 98-04